Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: HCA BAYSHORE MEDICAL CENTER 3701 KIRBY DRIVE SUITE 1288 HOUSTON TX 77098-3926	MFDR Tracking #: M4-05-B302-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: DEER PARK ISD Box #: 47	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pursuant to the TWCC fee guidelines, the claim pertaining to dates of service: 08/16/2004 – 08/19/2004, is to be paid…per diem rate…" "…it is the position of HCA Bayshore Medical Center that all charges relating to the admission of [Claimant] are due and payable as provided under Texas law."

Amount in Dispute: $2,106.38

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment made fair & reasonable rate for emergency admission one day only (Primary diagnosis trauma code) HAS methodology was used for reimbursement no pre-auth or concurrent review received to determine length of stay after emergency."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
8/16/2004 through 8/19/2004	M, A, O	Inpatient Admission	$2,106.38	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on August 11, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on August 17, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - M-No maximum allowable reimbursement.
   - A-Preauthorization required but not requested.
   - O-Denial after reconsideration.
   - TWCC Question Resolution Log Volume III (T.W.C.C. has provided further explanation of Rule 133.1 and 133.304) confirms that health care providers are limited to one request for reconsideration of the carrier's final action on a medical bill or preauthorization request. The record shows that a request for reconsideration has previously been addressed and response mailed to HCA Bayshore Medical Center. A copy of that response is attached. No further consideration of this bill can be made at this time.
   - Payment for this bill was made at a fair and reasonable rate for emergency admission one day only. (Primary

diagnosis trauma code). HAS methodology allows 2 x rate allowed by TWCC rule 134.401 for first payable day. 2 x 870= 1740 plus CT scan 283.18 (Medicare allowable plus 25%) and MRI brain 1254.49 (Medicare allowable plus 25%).

- No preauthorization or concurrent review received. One day allowed for emergency admit. Two additional days denied for lack of preauthorization since no concurrent review. No documentation received to support additional days at emergency rate. Post ICU shown on bill, no clarification of criteria for this rate, therefore payment made at medical rate.

2. Division rule at 28 TAC §134.600(b)(1)(A)**,** effective March 14, 2004, 29 TexReg 2360, states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (h) or (i) of this section only when the following situations occur: (A) "an emergency, as defined in §133.1 of this title (relating to Definitions)." The 8/16/2004 Emergency Physician report indicates that the claimant fell and struck his head. The claimant was taken to the hospital by EMS, and was evaluated in the emergency room. An MRI and CAT scan of his head and brain was performed that were negative for abnormalities. The claimant was assessed to have syncope, fever and dizziness. The respondent does not dispute that the initial day of hospitalization was for emergency treatment.
3. Division rule at 28 TAC §133.1(a)(7), effective July 15, 2000, defines an emergency as "Either a medical or mental health emergency as described below: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health and/or bodily functions in serious jeopardy, and/or serious dysfunction of any body organ or part." The Division finds that per the August 17, 2004 Consultation report by Dr. Jackie Allen Mullins the claimant had "Normal EKG. CBC and chemistries are unremarkable." Dr. Mullins assessed that the claimant had "Vago-mediated syncope, gastrointestinal illness, contusion, and history of possible cerebrovascular accident. Therefore, the inpatient hospitalization of August 17, 2004 through August 19, 2004 does not meet the definition of an emergency per Division rule at 28 TAC §133.1(a)(7).
4. Division rule at 28 TAC §134.600(h)(1)**,** effective March 14, 2004, 29 TexReg 2360, states "(h) The non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay." The Division finds that the requestor did not obtain preauthorization for the disputed inpatient hospitalization for dates of service August 17, 2004 through August 19, 2004 required per Division rule at 28 TAC §134.600(h)(1). Therefore, the insurance carrier's denial reason of "A" is supported.
5. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 850.11. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
6. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
7. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
8. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
9. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor's position statement states that "Pursuant to the TWCC fee guidelines, the claim pertaining to dates of service: 08/16/2004 – 08/19/2004, is to be paid…per diem rate…" "…it is the position of HCA Bayshore Medical Center that all charges relating to the admission of [Claimant] are due and payable as provided under Texas law."
- The requestor seeks reimbursement for this admission based upon the per diem reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(c)(5)(A).

- The requestor does not discuss or explain how payment of 50% of charges for the CT scan and MRI would result in a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

  "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

		11/04/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.